though their future contribution to patient care will be considerable, pharmacists and members of each of the other health disciplines should not try to completely "replace" the physician.

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The Contingency Fee

TO THE EDITOR: The recent recommendation by the California Citizens Committee on Tort Reform (CCCTR) to the California Medical Association's House of Delegates in Los Angeles that the contingency fee be retained was the only unpleasant surprise in an otherwise outstanding report. Even more disturbing was the fact that the House of Delegates concurred and actually defeated a proposal to condemn contingency fees on principle.

This action has to be a source of concern to anyone familiar with tort law. Justification of the contingency fee is based on the triad of "it is the poor man's key to the courthouse," "it discourages frivolous law suits" and "there is no alternative." Like most shibboleths that are never questioned, it is easily shown that these cliches are false. It is obvious that the contingency fee is not every poor man's key to the courthouse but only the key to that small percentage of poor men who have injuries sufficiently severe—that is, potential awards sufficiently large—to arouse some attorney's avarice. Furthermore lawyers are not obligated to use the contingency system; they may contract for a prepaid fee if it suits their convenience. The rich man may still obtain legal aid by the contract system where his lawyer does not feel the reward/risk ratio warrants use of the contingency fee. The poor man cannot. This is discrimination against poor or middle class litigants who are not severely disabled. It produces unequal access to justice based on wealth and circumstance.

The contingency fee is a capricious mechanism for discouraging nuisance suits because it is designed to encourage lawyers to accept cases on the possibility of a substantial award rather than on the basis of legal merit. It sacrifices the plaintiff's access to the courtroom and the defendant's protection against unwarranted litigation to a lawyer's decision to gamble his skill and case preparation costs against the chance of a sizable judgment. It is a rare lawyer who will not wager $15,000 preparation costs against 30 percent to 40 percent interest in a $1,000,000 settlement, even though there may be only nuisance value in the tort. Ambitious lawyers will often prosecute what previously has been an unmeritorious action in the hope of obtaining a valuable precedent. Indigent lawyers may take frivolous suits because they have nothing to lose. Ignorant lawyers prosecute cases with no merit because they do not know what merit is.

Personal injury suits are not always frivolous because the potential awards are small. A valid injustice, even though it be small, rankles as much as a large one. The boundary between "nuisance" and "significant" varies with the economic status of the observer. It is here that the two useful social functions claimed for the contingency fee come into conflict. It cannot act to screen nuisance suits without blocking the poor man's access to the courtroom; it cannot allow equal access to the courtroom without permitting nuisance suits.

One valid point made in Los Angeles was that from a tactical standpoint an attempt to eliminate the contingency fee would arouse such ferocious opposition as to jeopardize passage of the CCCTR package as a whole. Therefore it may be wise not to push for abolition at this time. However, it is important to distinguish between tactics and strategy and between compromise and integrity. To publicly express approval of the contingency fee is poor strategy because it will handicap any future efforts to eliminate it. Even more important, up to this point, physicians have successfully maintained an image of moral superiority in conflict with other groups over tort reform. To now

affirm that the contingency fee is a good system when doctors know it is a bad one is a surrender of integrity. This is particularly unwise because sooner or later the inequities of the system will become common knowledge. When this happens organized medicine will lose credibility and will sink in the public's estimation to the same ethical level as its opponents.

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FDA—The 11th Myth

TO THE EDITOR: This communication is occasioned by the publication of Food and Drug Administration (FDA) Commissioner Donald Kennedy's essay entitled "Ten Medical Myths About FDA," as well as by the editorial comment on the article, both in the December issue. After reading Commissioner Kennedy's statements to physicians, several comments seem most germane. I claim no expertise in most of the FDA's controversial activities (cyclamate, Laetrile) but do have some first hand knowledge of their behavior involving Controlled Substances (psychotropic drugs).

The Food, Drug and Cosmetic Act initially gave the FDA responsibility for insuring safety and efficacy of products that cross lines of interstate commerce. However, an attempt is now being made to extend these boundaries to include control by consideration of (real or fantasied) drug abuse risk/benefit in the country. Consequently, as recently as December 2, 1977, public hearings were held by the FDA in Washington with the intent of strictly limiting the use of amphetamines to narcolepsy and hyperkinesis. This represents an attempt by the FDA to abolish their use in obesity, depression and other conditions. These hearings were based on peculiarly "massaged" data published in the *Federal Register,* some challenged by subcontractors of the FDA and Defense Enforcement Administration and some —the Drug Abuse Warning Network (DAWN) data—openly acknowledged to be, at least in part, false. In addition, senior officials of the FDA are reported to have said that physicians who do not conform will be "open to medical malpractice."[1] One physician, Dr. Arnold Mandell, has already been prosecuted in California for prescribing amphetamines to *already drug abusing* football players in a psychotherapeutic strategy designed to get them drug free. Strong emphasis at the Board of Medical Quality Assurance administrative hearings was placed on the fact that Dr. Mandell did not adhere to the *Physicians' Desk Reference (PDR)* precise guidelines. Although FDA Commissioner Charles C. Edwards in 1972 in the *Federal Register* repudiated adherence to package inserts (and the *PDR*) as the ultimate guide to sound medical practice, and reemphasized clinical judgment as its ultimate source, the FDA seems to be fostering a movement away from that policy. The physician in charge of the FDA amphetamine hearings, after hearing testimony about the Mandell situation, stated openly that the FDA *made* regulations, but was not responsible for what happened to them thereafter (that is, we just built an atomic bomb, but it is not our responsibility who drops it).

An additional area of bureaucratic bumbling is the overlapping of the two FDA Controlled Substances committees and their "Catch 22" approach to marijuana research. This has led to the White House creation recently of a special National Institutes of Health committee to handle such problems, created in large part by the FDA. Specifically, I refer to their refusal until now to allow women of childbearing potential to enter marijuana chemotherapy research projects in cancer patients, despite the known teratogenic effects of the chemotherapeutic drugs. And, despite years of efforts by the scientific community, FDA has refused to agree to change marijuana from its Schedule I Controlled Substance classification (along with heroin and LSD) which, besides its absurdity, continues to bode ill for the research and treatment communities. FDA officials have also repeatedly stated that even at such time as Phase III studies have proven marijuana's medical usefulness, they will delay removing marijuana from Schedule I until a new drug application is filed (maybe another seven years). This, in almost all cases, depends upon a pharmaceutical company doing the necessary work to apply, which traditionally has rested on free enterprise and (understandably) a profit motive. But what about the patient, in the meantime?

I hope that physicians in all states are not deceived by fine words and offers of increasing communication without any commensurate action. In summary, the "11th myth" well may be that Commissioner Kennedy's ten medical myths really are only myths.

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